DEPARTMENT OF HEALTH AND HOSPITALS
Medicaid

BHSF Form 1-A
Issued 09/30/2013

Application for Health Coverage

THINGS TO KNOW

Use this application to see what coverage choices you qualify for

- Affordable private health insurance plans that offer comprehensive coverage to help you stay well
- A new tax credit that can immediately help pay your premiums for health coverage
- Free or low-cost insurance from Medicaid or the Louisiana Children's Health Insurance Program (LaCHIP)

You may qualify for a free or low-cost program even if you earn as much as $94,000 a year (for a family of 4).

Who can use this application?

- Use this application to apply for anyone in your family.
- Apply even if you or your child already has health coverage. You could be eligible for lower-cost or free coverage.
- Families that include immigrants can apply. You can apply for your child even if you aren't eligible for coverage. Applying won't affect your immigration status or chances of becoming a permanent resident or citizen.

Apply faster online

Apply faster online at www.medicaid.dhh.la.gov.

What you may need to apply

- Social Security Numbers (or document numbers for any legal immigrants who need insurance)
- Employer and income information for everyone in your family (for example, from paystubs, W-2 forms, or wage and tax statements)
- Policy numbers for any current health insurance
- Information about any job-related health insurance available to your family

Why do we ask for this information?

We ask about income and other information to let you know what coverage you qualify for and if you can get any help paying for it. **We'll keep all the information you provide private and secure, as required by law.**

What happens next?

Send your complete, signed application to the address on page 11. **If you don't have all the information we ask for, sign and submit your application anyway.** We'll follow-up with you within 1–2 weeks. You'll get instructions on any further steps to take. If you don't hear from us, visit www.medicaid.dhh.la.gov or call **1-888-342-6207**. Filling out this application doesn't mean you have to buy health coverage.

Get help with this application

- **Online:** www.medicaid.dhh.la.gov
- **Phone:** Call us at **1-888-342-6207.**
- **In person:** Visit our website or call **1-888-342-6207** to find the Medicaid office closest to you.
- ¿Necesita traductor de español? Llame al **1-888-342-6207.**
- Quí vị có cần thông dịch viên người Việt không? Nếu cần xin gọi số **1-888-342-6207.**

NEED HELP WITH YOUR APPLICATION? Visit www.medicaid.dhh.la.gov or call us at **1-888-342-6207**. If you need help in a language other than English, call **1-888-342-6207** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-800-220-5404**.

STEP 1 Tell us about yourself

(We need one adult in the family to be the contact person for your application.)

1. First name, Middle name, Last name, & Suffix			
2. Home address (Leave blank if you don't have one)			3. Apartment or suite number
4. City	5. State	6. ZIP code	7. Parish
8. Mailing address (if different from home address)			9. Apartment or suite number
10. City	11. State	12. ZIP code	13. Parish
14. Phone number ( ) –		15. Other phone number ( ) –	

16. Do you want to get information about this application by e-mail? ☐ Yes ☐ No

E-mail address: _____

17. What is your preferred spoken or written language (if not English)?

STEP 2 Tell us about your family

Who do you need to include on this application?

Tell us about all the family members who live with you. If you file taxes, we need to know about everyone on your tax return. (You don't need to file taxes to get health coverage).

DO Include:

- Yourself
- Your spouse
- Your children under 21 who live with you
- Your unmarried partner who needs health coverage
- Anyone you include on your tax return, even if they don't live with you
- Anyone else under 21 who you take care of and lives with you

You DON'T have to include:

- Your unmarried partner who doesn't need health coverage
- Your unmarried partner's children
- Your parents who live with you, but file their own tax return (if you're over 21)
- Other adult relatives who file their own tax return

The amount of assistance or type of program you qualify for depends on the number of people in your family and their incomes. This information helps us make sure everyone gets the best coverage they can.

Complete Step 2 for each person in your family. Start with yourself, then add other adults and children. If you have more than 4 people in your family, you'll need to make a copy of the pages and attach them. You don't need to provide immigration status or a Social Security Number (SSN) for family members who don't need health coverage. We'll keep all the information you provide private and secure as required by law. We'll use personal information only to check if you're eligible for health coverage.

NEED HELP WITH YOUR APPLICATION? Visit www.medicaid.dhh.la.gov or call us at **1-888-342-6207**. If you need help in a language other than English, call **1-888-342-6207** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-800-220-5404**.

STEP 2: PERSON 1 (Start with yourself)

Complete Step 2 for yourself, your spouse/partner, and children who live with you and/or anyone on your same federal income tax return if you file one. See page 1 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

1. First name, Middle name, Last name, & Suffix

2. Relationship to you? **SELF**

3. Date of birth (mm/dd/yyyy)

4. Sex ☐ Male ☐ Female

5. Social Security number (SSN) ___ ___ ___ - ___ ___ - ___ ___ ___ ___

We need this if you want health coverage and have an SSN. Providing your SSN can be helpful even if you don't want health coverage, and can speed up the application process. We use SSNs to check income and other information to see who's eligible for help with health coverage costs. If someone wants help getting an SSN, call **1-800-772-1213** or visit www.socialsecurity.gov. TTY users should call **1-800-325-0778**.

6. **Do you plan to file a federal income tax return NEXT YEAR?**
(You can still apply for health insurance even if you don't file a federal income tax return.)

☐ **YES. If yes,** please answer questions a–c. ☐ **NO. If no,** skip to question c.

a. Will you file jointly with a spouse? ☐ Yes ☐ No

If yes, name of spouse: _____

b. Will you claim any dependents on your tax return? ☐ Yes ☐ No

If yes, list name(s) of dependents: _____

c. Will you be claimed as a dependent on someone's tax return? ☐ Yes ☐ No

If yes, please list the name of the tax filer: _____

How are you related to the tax filer? _____

7. Are you pregnant? ☐ Yes ☐ No

a. **If yes,** how many babies are expected during this pregnancy? _____ b. Due date (mm/dd/yyyy): _____

8. **Do you need health coverage?**
(Even if you have insurance, there might be a program with better coverage or lower costs.)

☐ **YES. If yes**, answer all the questions below. ☐ **NO. If no,** SKIP to the income questions on page 3. Leave the rest of this page blank.

9. Do you have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.)? ☐ Yes ☐ No **If yes,** you'll need to complete and include Appendix D.

10. Do you live in a medical facility or nursing home? ☐ Yes ☐ No **If yes,** you'll need to complete and include Appendix D.

11. Are you a U.S. citizen or U.S. national? ☐ Yes ☐ No **If yes,** skip to question 13.

12. **If you aren't a U.S. citizen or U.S. national,** do you have eligible immigration status?

☐ Yes. Fill in your document type and ID number below.

a. Immigration document type _____ b. Document ID number _____

c. Have you lived in the U.S. since 1996? ☐ Yes ☐ No

d. Are you, or your spouse or parent a veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

13. Do you want help paying for medical bills from the last 3 months? ☐ Yes ☐ No

14. Do you live with at least one child under the age of 19, and are you the main person taking care of this child? ☐ Yes ☐ No

15. Are you a full-time student? ☐ Yes ☐ No

16. Were you in foster care at age 18 or older? ☐ Yes ☐ No

17. **If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)**

☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

18. **Race (OPTIONAL—check all that apply.)**

☐ White
☐ Black or African American
☐ American Indian or Alaska Native
☐ Asian Indian
☐ Chinese
☐ Filipino
☐ Japanese
☐ Korean
☐ Vietnamese
☐ Other Asian
☐ Native Hawaiian
☐ Guamanian or Chamorro
☐ Samoan
☐ Other Pacific Islander
☐ Other _____

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STEP 2: PERSON 1 (Continue with yourself)

Current Job & Income Information

☐ **Employed**
If you're currently employed, tell us about your income. Start with question 19.

☐ **Not employed**
Skip to question 29.

☐ **Self-employed**
Skip to question 28.

CURRENT JOB 1:

19. Employer name and address

20. Employer phone number
( ) –

21. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

$ _____

22. Average hours worked each WEEK

CURRENT JOB 2: (If you have more jobs and need more space, attach another sheet of paper.)

23. Employer name and address

24. Employer phone number
( ) –

25. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

$ _____

26. Average hours worked each WEEK

27. **In the past year, did you:** ☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

28. **If self-employed, answer the following questions:**

a. Type of work

_____

b. How much net income (profits once business expenses are paid) will you get from this self-employment this month?

$ _____

29. **OTHER INCOME THIS MONTH:** Check all that apply, and give the amount and how often you get it.

NOTE: You don't need to tell us about child support, veteran's payment, or Supplemental Security Income (SSI).

☐ None
☐ Unemployment $ _____ How often? _____
☐ Pensions $ _____ How often? _____
☐ Social Security $ _____ How often? _____
☐ Retirement accounts $ _____ How often? _____
☐ Alimony received $ _____ How often? _____
☐ Net farming/fishing $ _____ How often? _____
☐ Net rental/royalty $ _____ How often? _____
☐ Other income Type: _____
$ _____ How often? _____

30. **DEDUCTIONS:** Check all that apply, and give the amount and how often you get it.

If you pay for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.

NOTE: You shouldn't include a cost that you already considered in your answer to net self-employment (question 28b).

☐ Alimony paid $ _____ How often? _____
☐ Student loan interest $ _____ How often? _____
☐ Other deductions Type: _____
$ _____ How often? _____

31. **YEARLY INCOME: Complete only if your income changes from month to month.**

If you don't expect changes to your monthly income, skip to the next person.

Your total income **this year**	Your total income **next** year (if you think it will be different)
$	$

THANKS! This is all we need to know about you.

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STEP 2: PERSON 2

Complete Step 2 for yourself, your spouse/partner, and children who live with you and/or anyone on your same federal income tax return if you file one. See page 1 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

1. First name, Middle name, Last name, & Suffix | 2. Relationship to you?

3. Date of birth (mm/dd/yyyy) | 4. Sex ☐ Male ☐ Female

5. Social Security number (SSN) ___ ___ ___ - ___ ___ - ___ ___ ___ ___
We need this if you want health coverage and have an SSN.

6. Does PERSON 2 live at the same address as you? ☐ Yes ☐ No
If no, list address: _____

7. **Does PERSON 2 plan to file a federal income tax return NEXT YEAR?**
(You can still apply for health insurance even if you don't file a federal income tax return.)

☐ **YES. If yes,** please answer questions a–c. ☐ **NO. If no,** skip to question c.

a. Will PERSON 2 file jointly with a spouse? ☐ Yes ☐ No
If yes, name of spouse: _____

b. Will PERSON 2 claim any dependents on his or her tax return? ☐ Yes ☐ No
If yes, list name(s) of dependents: _____

c. Will PERSON 2 be claimed as a dependent on someone's tax return? ☐ Yes ☐ No
If yes, please list the name of the tax filer: _____
How is PERSON 2 related to the tax filer? _____

8. Is PERSON 2 pregnant? ☐ Yes ☐ No
a. **If yes,** how many babies are expected during this pregnancy? _____ b. Due date (mm/dd/yyyy): _____

9. **Does PERSON 2 need health coverage?**
(Even if they have insurance, there might be a program with better coverage or lower costs.)

☐ **YES. If yes**, answer all the questions below. ☐ **NO. If no,** SKIP to the income questions on page 5. Leave the rest of this page blank.

10. Does PERSON 2 have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.)? ☐ Yes ☐ No **If yes,** you'll need to complete and include Appendix D.

11. Does PERSON 2 live in a medical facility or nursing home? ☐ Yes ☐ No **If yes,** you'll need to complete and include Appendix D.

12. Is PERSON 2 a U.S. citizen or U.S. national? ☐ Yes ☐ No **If yes,** skip to question 14.

13. **If PERSON 2 isn't a U.S. citizen or U.S. national,** do they have eligible immigration status?
☐ Yes. Fill in their document type and ID number below.
a. Document type _____ b. Document ID number _____
c. Has PERSON 2 lived in the U.S. since 1996? ☐ Yes ☐ No d. Is PERSON 2, or their spouse or parent a veteran or an active-duty member in the U.S. military? ☐ Yes ☐ No

14. Does PERSON 2 want help paying for medical bills from the last 3 months? ☐ Yes ☐ No

15. Does PERSON 2 live with at least one child under the age of 19, and are they the main person taking care of this child? ☐ Yes ☐ No

16. Was PERSON 2 in foster care at age 18 or older? ☐ Yes ☐ No

Please answer the following questions if PERSON 2 is 22 or younger:

17. Did PERSON 2 have insurance through a job and lose it within the past 3 months? ☐ Yes ☐ No
a. **If yes**, end date: _____ b. Reason the insurance ended: _____

18. Is PERSON 2 a full-time student? ☐ Yes ☐ No

19. **If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)**
☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

20. **Race (OPTIONAL—check all that apply.)**

☐ White	☐ American Indian or Alaska Native	☐ Filipino	☐ Vietnamese	☐ Guamanian or Chamorro
☐ Black or African American	☐ Asian Indian	☐ Japanese	☐ Other Asian	☐ Samoan
	☐ Chinese	☐ Korean	☐ Native Hawaiian	☐ Other Pacific Islander
				☐ Other _____

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STEP 2: PERSON 2 (Continue with PERSON 2)

Current Job & Income Information

☐ **Employed**
If PERSON 2 is currently employed, tell us about their income. Start with question 21.

☐ **Not employed**
Skip to question 31.

☐ **Self-employed**
Skip to question 30.

CURRENT JOB 1:

21. Employer name and address

22. Employer phone number
( ) –

23. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

$ _____

24. Average hours worked each WEEK

CURRENT JOB 2: (If PERSON 2 has more jobs and you need more space, attach another sheet of paper.)

25. Employer name and address

26. Employer phone number
( ) –

27. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

$ _____

28. Average hours worked each WEEK

29. **In the past year, did PERSON 2:** ☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

30. **If PERSON 2 is self-employed, answer the following questions:**

a. Type of work

_____

b. How much net income (profits once business expenses are paid) will PERSON 2 get from this self-employment this month?

$ _____

31. **OTHER INCOME THIS MONTH:** Check all that apply, and give the amount and how often PERSON 2 gets it.

NOTE: You don't need to tell us about child support, veteran's payment, or Supplemental Security Income (SSI).

☐ None
☐ Unemployment $ _____ How often? _____
☐ Pensions $ _____ How often? _____
☐ Social Security $ _____ How often? _____
☐ Retirement accounts $ _____ How often? _____
☐ Alimony received $ _____ How often? _____
☐ Net farming/fishing $ _____ How often? _____
☐ Net rental/royalty $ _____ How often? _____
☐ Other income Type: _____
$ _____ How often? _____

32. **DEDUCTIONS:** Check all that apply, and give the amount and how often PERSON 2 gets it.

If PERSON 2 pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.

NOTE: You shouldn't include a cost that you already considered in your answer to net self-employment (question 30b).

☐ Alimony paid $ _____ How often? _____
☐ Student loan interest $ _____ How often? _____
☐ Other deductions Type: _____
$ _____ How often? _____

33. **YEARLY INCOME: Complete only if PERSON 2's income changes from month to month.**

If you don't expect changes to PERSON 2's monthly income, add another person or skip to the next section.

PERSON 2's total income **this year**	PERSON 2's total income **next year** (if you think it will be different)
$	$

THANKS! This is all we need to know about PERSON 2.

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STEP 2: PERSON 3

Complete Step 2 for yourself, your spouse/partner, and children who live with you and/or anyone on your same federal income tax return if you file one. See page 1 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

1. First name, Middle name, Last name, & Suffix | 2. Relationship to you?

3. Date of birth (mm/dd/yyyy) | 4. Sex ☐ Male ☐ Female

5. Social Security number (SSN) ___ ___ ___ - ___ ___ - ___ ___ ___ ___
We need this if you want health coverage and have an SSN.

6. Does PERSON 3 live at the same address as you? ☐ Yes ☐ No
If no, list address: _____

7. **Does PERSON 3 plan to file a federal income tax return NEXT YEAR?**
(You can still apply for health insurance even if you don't file a federal income tax return.)

☐ **YES. If yes,** please answer questions a–c. ☐ **NO. If no,** skip to question c.

a. Will PERSON 3 file jointly with a spouse? ☐ Yes ☐ No
If yes, name of spouse: _____

b. Will PERSON 3 claim any dependents on his or her tax return? ☐ Yes ☐ No
If yes, list name(s) of dependents: _____

c. Will PERSON 3 be claimed as a dependent on someone's tax return? ☐ Yes ☐ No
If yes, please list the name of the tax filer: _____
How is PERSON 3 related to the tax filer? _____

8. Is PERSON 3 pregnant? ☐ Yes ☐ No
a. **If yes,** how many babies are expected during this pregnancy? _____ b. Due date (mm/dd/yyyy): _____

9. **Does PERSON 3 need health coverage?**
(Even if they have insurance, there might be a program with better coverage or lower costs.)

☐ **YES. If yes**, answer all the questions below. ☐ **NO. If no,** SKIP to the income questions on page 7. Leave the rest of this page blank.

10. Does PERSON 3 have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.)? ☐ Yes ☐ No **If yes,** you'll need to complete and include Appendix D.

11. Does PERSON 3 live in a medical facility or nursing home? ☐ Yes ☐ No **If yes,** you'll need to complete and include Appendix D.

12. Is PERSON 3 a U.S. citizen or U.S. national? ☐ Yes ☐ No **If yes,** skip to question 14.

13. **If PERSON 3 isn't a U.S. citizen or U.S. national,** do they have eligible immigration status?
☐ Yes. Fill in their document type and ID number below.
a. Document type _____ b. Document ID number _____
c. Has PERSON 3 lived in the U.S. since 1996? ☐ Yes ☐ No d. Is PERSON 3, or their spouse or parent a veteran or an active-duty member in the U.S. military? ☐ Yes ☐ No

14. Does PERSON 3 want help paying for medical bills from the last 3 months? ☐ Yes ☐ No

15. Does PERSON 3 live with at least one child under the age of 19, and are they the main person taking care of this child? ☐ Yes ☐ No

16. Was PERSON 3 in foster care at age 18 or older? ☐ Yes ☐ No

Please answer the following questions if PERSON 3 is 22 or younger:

17. Did PERSON 3 have insurance through a job and lose it within the past 3 months? ☐ Yes ☐ No
a. **If yes**, end date: _____ b. Reason the insurance ended: _____

18. Is PERSON 3 a full-time student? ☐ Yes ☐ No

19. **If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)**
☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

20. **Race (OPTIONAL—check all that apply.)**

☐ White	☐ American Indian or Alaska Native	☐ Filipino	☐ Vietnamese	☐ Guamanian or Chamorro
☐ Black or African American	☐ Asian Indian	☐ Japanese	☐ Other Asian	☐ Samoan
	☐ Chinese	☐ Korean	☐ Native Hawaiian	☐ Other Pacific Islander
				☐ Other _____

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STEP 2: PERSON 3 (Continue with PERSON 3)

Current Job & Income Information

☐ **Employed**
If PERSON 3 is currently employed, tell us about their income. Start with question 21.

☐ **Not employed**
Skip to question 31.

☐ **Self-employed**
Skip to question 30.

CURRENT JOB 1:

21. Employer name and address

22. Employer phone number
( ) –

23. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

$ _____

24. Average hours worked each WEEK

CURRENT JOB 2: (If PERSON 3 has more jobs and you need more space, attach another sheet of paper.)

25. Employer name and address

26. Employer phone number
( ) –

27. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

$ _____

28. Average hours worked each WEEK

29. **In the past year, did PERSON 3:** ☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

30. **If PERSON 3 is self-employed, answer the following questions:**

a. Type of work

_____

b. How much net income (profits once business expenses are paid) will PERSON 3 get from this self-employment this month?

$ _____

31. **OTHER INCOME THIS MONTH:** Check all that apply, and give the amount and how often PERSON 3 gets it.

NOTE: You don't need to tell us about child support, veteran's payment, or Supplemental Security Income (SSI).

☐ None
☐ Unemployment $ _____ How often? _____
☐ Pensions $ _____ How often? _____
☐ Social Security $ _____ How often? _____
☐ Retirement accounts $ _____ How often? _____
☐ Alimony received $ _____ How often? _____
☐ Net farming/fishing $ _____ How often? _____
☐ Net rental/royalty $ _____ How often? _____
☐ Other income Type: _____
$ _____ How often? _____

32. **DEDUCTIONS:** Check all that apply, and give the amount and how often PERSON 3 gets it.

If PERSON 3 pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.

NOTE: You shouldn't include a cost that you already considered in your answer to net self-employment (question 30b).

☐ Alimony paid $ _____ How often? _____
☐ Student loan interest $ _____ How often? _____
☐ Other deductions Type: _____
$ _____ How often? _____

33. **YEARLY INCOME: Complete only if PERSON 3's income changes from month to month.**

If you don't expect changes to PERSON 3's monthly income, add another person or skip to the next section.

PERSON 3's total income **this year**	PERSON 3's total income **next year** (if you think it will be different)
$	$

THANKS! This is all we need to know about PERSON 3.

NEED HELP WITH YOUR APPLICATION? Visit www.medicaid.dhh.la.gov or call us at **1-888-342-6207**. If you need help in a language other than English, call **1-888-342-6207** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-800-220-5404**.

STEP 2: PERSON 4

Complete Step 2 for yourself, your spouse/partner, and children who live with you and/or anyone on your same federal income tax return if you file one. See page 1 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

1. First name, Middle name, Last name, & Suffix | 2. Relationship to you?

3. Date of birth (mm/dd/yyyy) | 4. Sex ☐ Male ☐ Female

5. Social Security number (SSN) ___ ___ ___ - ___ ___ - ___ ___ ___ ___
We need this if you want health coverage and have an SSN.

6. Does PERSON 4 live at the same address as you? ☐ Yes ☐ No
If no, list address: _____

7. **Does PERSON 4 plan to file a federal income tax return NEXT YEAR?**
(You can still apply for health insurance even if you don't file a federal income tax return.)

☐ **YES. If yes,** please answer questions a–c. ☐ **NO. If no,** skip to question c.

a. Will PERSON 4 file jointly with a spouse? ☐ Yes ☐ No
If yes, name of spouse: _____

b. Will PERSON 4 claim any dependents on his or her tax return? ☐ Yes ☐ No
If yes, list name(s) of dependents: _____

c. Will PERSON 4 be claimed as a dependent on someone's tax return? ☐ Yes ☐ No
If yes, please list the name of the tax filer: _____
How is PERSON 4 related to the tax filer? _____

8. Is PERSON 4 pregnant? ☐ Yes ☐ No
a. **If yes,** how many babies are expected during this pregnancy? _____ b. Due date (mm/dd/yyyy): _____

9. **Does PERSON 4 need health coverage?**
(Even if they have insurance, there might be a program with better coverage or lower costs.)

☐ **YES. If yes**, answer all the questions below. ☐ **NO. If no,** SKIP to the income questions on page 9. Leave the rest of this page blank.

10. Does PERSON 4 have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.)? ☐ Yes ☐ No **If yes,** you'll need to complete and include Appendix D.

11. Does PERSON 4 live in a medical facility or nursing home? ☐ Yes ☐ No **If yes,** you'll need to complete and include Appendix D.

12. Is PERSON 4 a U.S. citizen or U.S. national? ☐ Yes ☐ No **If yes,** skip to question 14.

13. **If PERSON 4 isn't a U.S. citizen or U.S. national,** do they have eligible immigration status?
☐ Yes. Fill in their document type and ID number below.
a. Document type _____ b. Document ID number _____
c. Has PERSON 4 lived in the U.S. since 1996? ☐ Yes ☐ No d. Is PERSON 4, or their spouse or parent a veteran or an active-duty member in the U.S. military? ☐ Yes ☐ No

14. Does PERSON 4 want help paying for medical bills from the last 3 months? ☐ Yes ☐ No

15. Does PERSON 4 live with at least one child under the age of 19, and are they the main person taking care of this child? ☐ Yes ☐ No

16. Was PERSON 4 in foster care at age 18 or older? ☐ Yes ☐ No

Please answer the following questions if PERSON 4 is 22 or younger:

17. Did PERSON 4 have insurance through a job and lose it within the past 3 months? ☐ Yes ☐ No
a. **If yes**, end date: _____ b. Reason the insurance ended: _____

18. Is PERSON 4 a full-time student? ☐ Yes ☐ No

19. **If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)**
☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

20. **Race (OPTIONAL—check all that apply.)**

☐ White	☐ American Indian or Alaska Native	☐ Filipino	☐ Vietnamese	☐ Guamanian or Chamorro
☐ Black or African American	☐ Asian Indian	☐ Japanese	☐ Other Asian	☐ Samoan
	☐ Chinese	☐ Korean	☐ Native Hawaiian	☐ Other Pacific Islander
				☐ Other _____

NEED HELP WITH YOUR APPLICATION? Visit www.medicaid.dhh.la.gov or call us at **1-888-342-6207**. If you need help in a language other than English, call **1-888-342-6207** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-800-220-5404**.

STEP 2: PERSON 4 (Continue with PERSON 4)

Current Job & Income Information

☐ **Employed**
If PERSON 4 is currently employed, tell us about their income. Start with question 21.

☐ **Not employed**
Skip to question 31.

☐ **Self-employed**
Skip to question 30.

CURRENT JOB 1:

21. Employer name and address

22. Employer phone number
( ) –

23. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

$ _____

24. Average hours worked each WEEK

CURRENT JOB 2: (If PERSON 4 has more jobs and you need more space, attach another sheet of paper.)

25. Employer name and address

26. Employer phone number
( ) –

27. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

$ _____

28. Average hours worked each WEEK

29. **In the past year, did PERSON 4:** ☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

30. **If PERSON 4 is self-employed, answer the following questions:**

a. Type of work

_____

b. How much net income (profits once business expenses are paid) will PERSON 4 get from this self-employment this month?

$ _____

31. **OTHER INCOME THIS MONTH:** Check all that apply, and give the amount and how often PERSON 4 gets it.

NOTE: You don't need to tell us about child support, veteran's payment, or Supplemental Security Income (SSI).

☐ None
☐ Unemployment $ _____ How often? _____
☐ Pensions $ _____ How often? _____
☐ Social Security $ _____ How often? _____
☐ Retirement accounts $ _____ How often? _____
☐ Alimony received $ _____ How often? _____
☐ Net farming/fishing $ _____ How often? _____
☐ Net rental/royalty $ _____ How often? _____
☐ Other income Type: _____
$ _____ How often? _____

32. **DEDUCTIONS:** Check all that apply, and give the amount and how often PERSON 4 gets it.

If PERSON 4 pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.

NOTE: You shouldn't include a cost that you already considered in your answer to net self-employment (question 30b).

☐ Alimony paid $ _____ How often? _____
☐ Student loan interest $ _____ How often? _____
☐ Other deductions Type: _____
$ _____ How often? _____

33. **YEARLY INCOME: Complete only if PERSON 4's income changes from month to month.**

If you don't expect changes to PERSON 4's monthly income, add another person or skip to the next section.

PERSON 4's total income **this year**	PERSON 4's total income **next year** (if you think it will be different)
$	$

THANKS! This is all we need to know about PERSON 4.

If you have more than four people to include, visit www.medicaid.dhh.la.gov to download and print additional pages or make a copy of pages 8 and 9 and complete.

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STEP 3 American Indian or Alaska Native (AI/AN) family member(s)

1. Are you or is anyone in your family American Indian or Alaska Native?

☐ If **No,** skip to Step 4.

☐ **Yes. If yes,** go to Appendix B.

STEP 4 Your Family's Health Coverage

Answer these questions for anyone who needs health coverage.

1. **Is anyone enrolled in health coverage now from the following?**

☐ **YES. If yes**, check the type of coverage and write the person(s)' name(s) next to the coverage they have. ☐ **NO.**

☐ Medicaid _____

☐ CHIP _____

☐ Medicare _____

☐ TRICARE (Don't check if you have direct care or Line of Duty)

_____

☐ VA health care programs _____

☐ Peace Corps _____

☐ Employer insurance _____

Name of health insurance: _____

Policy number: _____

Is this COBRA coverage? ☐ Yes ☐ No

Is this a retiree health plan? ☐ Yes ☐ No

☐ Other

Name of health insurance: _____

Policy number: _____

Is this a limited-benefit plan (like a school accident policy)?

☐ Yes ☐ No

2. **Is anyone listed on this application offered health coverage from a job?** This could be from their own job or from someone else's job, such as a parent or spouse. .

☐ **YES. If yes,** you'll need to complete and include Appendix A. Is this a state employee benefit plan? ☐ Yes ☐ No

☐ **NO. If no, continue to Step 5.**

STEP 5 Read & sign this application

- I'm signing this application under penalty of perjury which means I've provided true answers to all the questions on this form to the best of my knowledge. I know that I may be subject to penalties under federal law if I provide false or untrue information.
- I know that I must tell Medicaid if anything changes (and is different than) what I wrote on this application. I can visit www.medicaid.dhh.la.gov or call **1-888-342-6207** to report any changes. I understand that a change in my information could affect the eligibility for member(s) of my household.
- I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting www.hhs.gov/ocr/office/file, calling the US DHHS Regional Office for Civil Rights at **1-800-368-1019**, or writing to Louisiana DHH at **PO Box 4818, Baton Rouge, Louisiana 70821**.
- I confirm that no one applying for health insurance on this application is incarcerated (detained or jailed), and if they are that I must report it.

Is anyone applying for coverage on this application incarcerated (detained or jailed)?

☐ Yes ☐ No **If yes,** who is incarcerated?: _____
(name of person)

We need the information you provide on this application to check your eligibility for help paying for health coverage if you choose to apply. We'll check your answers using information in our electronic databases and databases from the Internal Revenue Service (IRS), Social Security, the Department of Homeland Security, and/or a consumer reporting agency. If the information doesn't match, we may ask you to send us proof.

NEED HELP WITH YOUR APPLICATION? Visit www.medicaid.dhh.la.gov or call us at **1-888-342-6207**. If you need help in a language other than English, call **1-888-342-6207** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-800-220-5404**.

STEP 5 Read & sign this application (continued)

Renewal of coverage in future years
To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow Medicaid to use income data, including information from tax returns. Medicaid will send me a notice, let me make any changes, and I can opt out at any time.

☐ Yes, renew my eligibility automatically for the next (choose one): ☐ 5 years ☐ 4 years ☐ 3 years ☐ 2 years ☐ 1 year

☐ No, don't use information from tax returns to renew my coverage.

If anyone on this application is eligible for Medicaid

- I am giving to the Medicaid agency our rights to pursue and get any money from other health insurance, legal settlements, or other third parties. I am also giving to the Medicaid agency rights to pursue and get medical support from a spouse or parent.

Does any child on this application have a parent living outside of the home? ☐ Yes ☐ No

- **If yes,** I know I will be asked to cooperate with the agency that collects medical support from an absent parent. If I think that cooperating to collect medical support will harm me or my children, I can tell Medicaid and I may not have to cooperate.

Estate Recovery

I understand that Estate Recovery rules require Louisiana Medicaid to recover the cost of certain Medicaid payments from the applicant's estate. These costs include the total amount of payments for facility services, hospital care, payments to HCBS or PACE providers, and prescription drugs received at age 55 or older. The estate is the property owned at the time of death. Medicaid will not make a claim against the estate while the applicant or his or her legal spouse is still living. Medicaid also will not make a claim if the applicant has a dependent child who is under age 21, blind, or disabled. Collection may not be made if it is not cost effective for Medicaid to do so, or if it would cause a hardship for the heirs of the estate. A hardship may exist if the estate property is the only source of income for the heirs, if that income is limited, or if there are other convincing situations.

My right to appeal

If I think the Health Insurance Marketplace or Louisiana Medicaid has made a mistake, I can appeal its decision. To appeal means to tell someone at the Health Insurance Marketplace or Medicaid that I think the action is wrong, and ask for a fair review of the action. I know that I can find out how to appeal by contacting Medicaid at **1-888-342-6207**. I know that I can be represented in the process by someone other than myself. My eligibility and other important information will be explained to me.

Sign this application

The person who filled out Step 1 should sign this application. If you're an authorized representative you may sign here, as long as you provide the information required in Appendix C.

Signature	Date (mm/dd/yyyy)

STEP 6 Mail completed application

Mail your signed application to:

Medicaid Application Office
P.O. Box 91278
Baton Rouge, LA 70821-9893

PRA Disclosure Statement
According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1191. The time required to complete this information collection is estimated to average [Insert Time (hours or minutes)] per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

NEED HELP WITH YOUR APPLICATION? Visit www.medicaid.dhh.la.gov or call us at **1-888-342-6207**. If you need help in a language other than English, call **1-888-342-6207** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-800-220-5404**.

APPENDIX A

Health Coverage from Jobs

You **DON'T** need to answer these questions unless someone in the household is eligible for health coverage from a job. Attach a copy of this page for each job that offers coverage.

Tell us about the **job** that offers coverage.

Take the Employer Coverage Tool on the next page to the employer who offers coverage to help you answer these questions. You only need to include this page when you send in your application, not the Employer Coverage Tool.

EMPLOYEE Information

1. Employee name (First, Middle, Last)	2. Employee Social Security number ___ ___ ___ - ___ ___ - ___ ___ ___ ___

EMPLOYER Information

3. Employer name	4. Employer Identification Number (EIN) ___ ___ - ___ ___ ___ ___ ___ ___ ___
5. Employer address	6. Employer phone number ( ) –

7. City	8. State	9. ZIP code

10. Who can we contact about employee health coverage at this job?

11. Phone number (if different from above) ( ) –	12. E-mail address

13. **Are you currently eligible for coverage offered by this employer, or will you become eligible in the next 3 months?**

☐ **Yes** (Continue)

13a. If you're in a waiting or probationary period, when can you enroll in coverage? _____ (mm/dd/yyyy)

List the names of anyone else who is eligible for coverage from this job.

Name: _____ Name: _____ Name: _____

☐ **No** (Stop here and go to Step 5 in the application)

Tell us about the **health plan** offered by this employer.

14. Does the employer offer a health plan that meets the minimum value standard*? ☐ Yes ☐ No

15. For the lowest-cost plan that meets the minimum value standard* offered **only to the employee** (don't include family plans):
If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? **$** _____

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Once a month ☐ Quarterly ☐ Yearly

16. What change will the employer make for the new plan year (if known)?

☐ Employer won't offer health coverage.

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much will the employee have to pay in premiums for that plan? **$** _____

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Once a month ☐ Quarterly ☐ Yearly

Date of change (mm/dd/yyyy): _____

* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

EMPLOYER COVERAGE TOOL

Use this tool to help answer questions in Appendix A about any employer health coverage that you're eligible for (even if it's from another person's job, like a parent or spouse). The information in the numbered boxes below match the boxes on Appendix A. For example, the answer to question 14 on this page should match question 14 on Appendix A.

Write your name and Social Security number in boxes 1 and 2 and ask the employer to fill out the rest of the form. Complete one tool for each employer that offers health coverage.

EMPLOYEE Information

The **employee** needs to fill out this section.

1. Employee name (First, Middle, Last)	2. Employee Social Security number ___ ___ ___ - ___ ___ - ___ ___ ___ ___

EMPLOYER Information

Ask the **employer** for this information.

3. Employer name	4. Employer Identification Number (EIN) ___ ___ - ___ ___ ___ ___ ___ ___ ___
5. Employer address	6. Employer phone number ( ) –

7. City	8. State	9. ZIP code

10. Who can we contact about employee health coverage at this job?

11. Phone number (if different from above) ( ) –	12. E-mail address

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☐ **Yes** (Continue)

13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? _____ (mm/dd/yyyy)

☐ **No** (STOP and return this form to employee)

Tell us about the **health plan** offered by this **employer**.

Does the employer offer a health plan that covers an employee's spouse or dependent?

☐ Yes. Which people? ☐ Spouse ☐ Dependent(s)

☐ No

(Go to question 14)

14. Does the employer offer a health plan that meets the minimum value standard*?

☐ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* offered **only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? **$** _____

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Once a month ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?

☐ Employer won't offer health coverage

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much will the employee have to pay in premiums for that plan? **$** _____

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Once a month ☐ Quarterly ☐ Yearly

Date of change (mm/dd/yyyy): _____

* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

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APPENDIX B

American Indian or Alaska Native Family Member (AI/AN)

Complete this appendix if you or any family members are American Indian or Alaska Native. Submit this with your Application for Health Coverage.

Tell us about your American Indian or Alaska Native family member(s).

American Indians and Alaska Natives may not have to pay cost sharing and may get special monthly enrollment periods. Answer the following questions to make sure your family gets the most help possible.

NOTE: If you have more people to include, make a copy of this page and attach.

	AI/AN PERSON 1	AI/AN PERSON 2
1. Name	First Middle Last	First Middle Last
2. Member of a federally recognized tribe?	☐ Yes **If yes**, what is the tribe's name _____ ☐ No	☐ Yes **If yes**, what is the tribe's name _____ ☐ No
3. Has this person ever gotten a service from the Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs?	☐ Yes ☐ No **If no**, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? ☐ Yes ☐ No	☐ Yes ☐ No **If no**, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? ☐ Yes ☐ No
4. Certain money received may not be counted. List any income (amount and how often) reported on your application that includes money from these sources: • Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties • Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations) • Money from selling things that have cultural significance	**$** _____ How often?_____	**$** _____ How often?_____

APPENDIX C

Assistance with Completing this Application

You can choose an authorized representative.

You can give a trusted person permission to talk about this application with us, see your information, and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an "authorized representative." If you ever need to change your authorized representative, contact Medicaid. If you're a legally appointed representative for someone on this application, submit proof with the application.

1. Name of authorized representative (First name, Middle name, Last name)		
2. Address		3. Apartment or suite number
4. City	5. State	6. ZIP code
7. Phone number ( ) –		
8. Organization name		9. ID number (if applicable)

By signing, you allow this person to sign your application, get official information about this application, and act for you on all future matters with this agency.

10. Your signature	11. Date (mm/dd/yyyy)

For certified Medicaid Application Centers only.

1. Application start date (mm/dd/yyyy)	
2. First name, Middle name, Last name, & Suffix	
3. Organization name	4. ID number (if applicable)

APPENDIX D

Personal Assets

Complete this appendix if anyone applying has a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.), lives in a medical facility or nursing home, or is 65 years of age or older.

DOES ANYONE IN YOUR HOME OWN...	ASSET VALUE (closest possible estimate)	DESCRIBE THIS ASSET (include names of banks and other companies)
Checking accounts ☐ Yes ☐ No Who owns this: _____	$ _____	
Savings accounts ☐ Yes ☐ No Who owns this: _____	$ _____	
Vehicles ☐ Yes ☐ No Who owns this: _____	$ _____	
Property other than your home ☐ Yes ☐ No Who owns this: _____	$ _____	
Certificates of Deposit (CDs) ☐ Yes ☐ No Who owns this: _____	$ _____	
Annuities, Trusts, Stocks, Bonds, or Retirement Accounts ☐ Yes ☐ No Who owns this: _____	$ _____	
Life or burial insurance. ☐ Yes ☐ No Who owns this: _____	$ _____	
Money set aside for burial or pre-need contract ☐ Yes ☐ No Who owns this: _____	$ _____	
Safe deposit boxes ☐ Yes ☐ No Who owns this: _____	$ _____	
Other (Please describe in detail) ☐ Yes ☐ No Who owns this: _____	$ _____	

STATE OF LOUISIANA
VOTER REGISTRATION AGENCIES
DECLARATION FORM

If you are not registered to vote where you live now, would you like to apply to register to vote here today? (Check one)

☐ I want to register to vote. ☐ I do not want to register to vote.

IF YOU DO NOT CHECK EITHER BOX, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME.

Applying to register or declining to register to vote **will not** affect the amount of assistance that you will be provided by this agency. Voter eligibility requirements are found on the voter registration application form.

Note: If you do register to vote, the location where your application was submitted will remain confidential. If you decline to register to vote, this fact will remain confidential. Applying to register or declining to register to vote will be used **only** for voter registration purposes.

If you would like help in filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application in private. (Check one)

☐ **Yes, I would like help.** ☐ **No, I do not want help.**

For assistance in completing the voter registration application form outside our office, contact Louisiana Department of Health and hospitals at 1-888-342-6207.

If completed outside our office, this declaration form and your completed voter registration application form (if you filled one out) should be returned to P.O. Box 91278 Baton Rouge, LA 70821-9278.

Signature or Mark **Name Typed or Printed** **Date**

Signatures of Two Witnesses If Signed With Mark:

1) _____ 2) _____

COMPLAINTS

If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with the Louisiana Secretary of State, Commissioner of Elections, P.O. Box 94125, Baton Rouge, LA 70804-9125 or by calling (225)922-0900 or 1-800-883-2805.

Comments/Remarks (for official use only):

USE THIS FORM TO: 1) register to vote 2) change your address 3) request a name change 4) change party affiliation

TO REGISTER TO VOTE AND BE ELIGIBLE TO VOTE YOU MUST: 1) be a United States citizen 2) be at least 17 years old to register but must be 18 years old to vote 3) not be under an order of imprisonment for conviction of a felony 4) not be under a judgment of full interdiction or limited interdiction where your right to vote has been suspended 5) reside in the state and parish in which you seek to register and vote.

INSTRUCTIONS FOR COMPLETING THIS FORM: All information except your signature should be printed clearly in ink, preferably black, or typed. Fill in all boxes that apply to you.

Box 1: Indicate whether you are a citizen of the United States of America. Indicate whether you will be 18 years of age on or before election day.

Box 2: Provide full name. Do not use initials for middle or maiden name.

Box 3: 'Residence Address' means the address where you live and are registering to vote. If you claim a homestead exemption, you must list the address of that residence. Do not use a post office box for your 'Residence Address'. If you use a rural route and box number, draw a map in the space labeled 'Give Location.' Write in the names of the crossroads (streets) nearest to where you live. Draw an X to show where you live. Use a dot to show any schools, churches, stores or landmarks near where you live and write the name of the landmark. Check the box provided if mail is not delivered to your residence address by the post office. Complete 'Mailing Address' only if it is different from the 'Residence Address' or if mail is not delivered to your residence address.

Boxes 5 & 13: You must provide your LA driver's license number or LA special identification card number, if issued. If not issued, you must provide at least the last four digits of your social security number, if issued. The full social security number may be provided on a voluntary basis. If neither a social security number nor a LA driver's license number or LA special identification card number has been issued, and this form is submitted by mail, and you are registering to vote for the first time, in order to avoid additional identification requirements for first time voters, attach either a) a copy of a current and valid photo identification or b) a copy of a current utility bill, bank statement, government check, paycheck, or other government document that shows your name and address.

Boxes 7, 11 & 12: The items 'race/ethnic origin', 'email' and 'phone' are not required but are helpful. Email is protected from disclosure by law.

Box 8: If you do not complete this item, your party affiliation will be listed as 'none', unless you are presently registered with a party affiliation and no change is being made today. If you are not registering with a political party, circle 'none'. The recognized political parties are Democrat, Green, Libertarian, Reform and Republican or you may specify any other party affiliation.

Box 17: If you are using this form to request a change of name, you must print the name to be changed here.

Box 18: Date and sign the card with your signature or mark.

If returned by mail, place in an envelope and mail to the appropriate registrar of voters at the address found on the reverse side of this card. If you have not been issued a social security number or Louisiana driver's license number, you must mail the required documentation with your application. Your application or envelope must be postmarked 30 days prior to the first election in which you seek to vote based on the residence listed on this application.

NOTE: 1. If you decline to register to vote, this fact will remain confidential and will be used only for voter registration purposes. If you register to vote, the office where your application was submitted will remain confidential and will be used only for voter registration purposes. 2. Your social security number will also remain confidential and is intended to be used for voter registration purposes only.

QUESTIONS? Call your Parish Registrar of Voters OR call the Department of State at **1-800-883-2805 or (225) 922-0900.**

COMPLETE AND CHECK ALL APPLICABLE BOXES AND CUT HERE BEFORE MAILING.

LOUISIANA VOTER REGISTRATION APPLICATION LR-1 &1M, FORM # 100

OFFICIAL USE ONLY
Wd / Dist _____ Pct _____ Reg Type _____ In/Out _____ REG # _____

1 Are you a citizen of the United States of America? YES ☐ NO ☐ Will you be 18 years of age on or before election day? YES ☐ NO ☐
If you checked 'no' in response to either of these questions, DO NOT COMPLETE THIS FORM.

2 NAME OF APPLICANT (PLEASE PRINT NAME)
LAST FIRST FULL MIDDLE OR MAIDEN

GIVE LOCATION

3 RESIDENCE ADDRESS (MUST BE ADDRESS WHERE YOU CLAIM HOMESTEAD EXEMPTION, IF ANY)
HOUSE OR APT. NO. & STREET (IF RURAL, ROUTE & BOX NO.) CITY OR TOWN STATE ZIP

If NO mail delivery to residential address, check here: ( )
MAILING ADDRESS, IF DIFFERENT

4 DATE OF BIRTH
MONTH DAY YEAR

5 * SOCIAL SECURITY # (CIRCLE ONE)
NO
YES # _____

6 SEX (CIRCLE ONE)
MALE FEMALE

7 ** RACE / ETHNIC ORIGIN (CIRCLE ONE)
WHITE BLACK ASIAN HISPANIC AMER. INDIAN
OTHER: _____

8 PARTY AFFILIATION (CIRCLE ONE)
DEM GRN LBT RFM REP NONE
OTHER (SPECIFY) _____

9 APPLICANT'S PLACE OF BIRTH
CITY OR TOWN PARISH OR COUNTY STATE COUNTRY

10 MOTHER'S MAIDEN NAME

11 **EMAIL

12 ** PHONE
HOME ( )
DAY ( )

13 LA DRIVER'S LICENSE / I.D. # (CIRCLE ONE)
NO
YES # _____

14 Will you require assistance at the polls?(CIRCLE ONE)
NO YES IF YES, GIVE REASON :

15 LAST RESIDENCE ADDRESS
ADDRESS

16 PLACE OF LAST REGISTRATION
PARISH OR COUNTY STATE

17 FORMER REGISTERED NAME, IF APPLICABLE

AFFIRMATION: I do hereby solemnly swear or affirm that I am a United States citizen, that I am at least 17 years old, that I am not currently under an order of imprisonment for conviction of a felony, that I am not currently under a judgment of full interdiction or limited interdiction where my right to vote has been suspended, that I am a bona fide resident of this state and parish, and that the facts given by me on this application are true to the best of my knowledge and belief. If I have provided false information, I may be subject to a fine of not more than $2,000 ($5,000 for subsequent offense) or imprisonment for not more than 2 year (5 years for subsequent offense), or both. Any false statement may constitute perjury.

18 SIGN YOUR NAME IN BOX AT RIGHT.

DATE: _____ / _____ / _____

19 IF YOU ARE UNABLE TO SIGN YOUR NAME, TWO WITNESSES TO YOUR MARK MUST SIGN HERE.
WITNESS SIGNATURE: WITNESS SIGNATURE:

*** Last 4 digits of the social security number required if no LA driver's license issued; social security number is intended to be used for voter registration purposes only; full # OPTIONAL. ** OPTIONAL**

ACADIA
568 NW Court Circle
Crowley, LA 70526-4363
(337) 788-6841

ALLEN
P. O. Box 150
Oberlin, LA 70655-0150
(337) 639-4966

ASCENSION
828 S. Irma Blvd. - #205
Gonzales, LA 70737-3631
(225) 621-5780

ASSUMPTION
P. O. Box 578
Napoleonville, LA 70390-0578
(985) 369-7347

AVOYELLES
312 N. Main St. - #E
Marksville, LA 71351-2409
(318) 253-7129

BEAUREGARD
P. O. Box 952
DeRidder, LA 70634-0952
(337) 463-7955

BIENVILLE
P. O. Box 697
Arcadia, LA 71001-0697
(318) 263-7407

BOSSIER
P. O. Box 635
Benton, LA 71006-0635
(318) 965-2301

CADDO
P. O. Box 1253
Shreveport, LA 71163-1253
(318) 226-6891

CALCASIEU
1000 Ryan St. - #7
Lake Charles, LA 70601-5250
(337) 437-3572

CALDWELL
P. O. Box 1107
Columbia, LA 71418-1107
(318) 649-7364

CAMERON
P. O. Box 1
Cameron, LA 70631-0001
(337) 775-5493

CATAHOULA
P. O. Box 215
Harrisonburg, LA 71340-0215
(318) 744-5745

CLAIBORNE
507 W. Main St. - Suite 1
Homer, LA 71040-3914
(318) 927-3332

CONCORDIA
4001 Carter St. - #4
Vidalia, LA 71373-3021
(318) 336-7770

DESOTO
105 Franklin St.
Mansfield, LA 71052-2046
(318) 872-1149

E. BATON ROUGE
222 St. Louis - #201
Baton Rouge, LA 70802-5860
(225) 389-3940

E. CARROLL
P. O. Box 708
Lake Providence, LA 71254-0708
(318) 559-2015

E. FELICIANA
P. O. Box 488
Clinton, LA 70722-0488
(225) 683-3105

EVANGELINE
200 Court St. - Ste. 102
Ville Platte, LA 70586-4463
(337) 363-5538

FRANKLIN
Courthouse
6560 Main St.
Winnsboro, LA 71295-2750
(318) 435-4489

GRANT
Courthouse
200 Main St.
Colfax, LA 71417-1828
(318) 627-9938

IBERIA
300 S. Iberia St. - #110
New Iberia, LA 70560-4543
(337) 369-4407

IBERVILLE
P. O. Box 554
Plaquemine, LA 70765-0554
(225) 687-5201

JACKSON
500 E. Court St. - #102
Jonesboro, LA 71251-3400
(318) 259-2486

JEFFERSON
P. O. Box 10494
Jefferson, LA 70181-0494
(504) 736-6191

JEFFERSON DAVIS
302 N. Cutting Ave.
Jennings, LA 70546-5361
(337) 824-0834

LAFAYETTE
1010 Lafayette St. - #313
Lafayette, LA 70501-6885
(337) 291-7140

LAFOURCHE
307 W. 4th St.
Thibodaux, LA 70301-3105
(985) 447-3256

LASALLE
P. O. Box 2439
Jena, LA 71342-2439
(318) 992-2254

LINCOLN
100 W. Texas Ave.
Ruston, LA 71270-4463
(318) 251-5110

LIVINGSTON
P. O. Box 968
Livingston, LA 70754-0968
(225) 686-3054

MADISON
100 N. Cedar St.
Tallulah, LA 71282-3892
(318) 574-2193

MOREHOUSE
129 N. Franklin St.
Bastrop, LA 71220-3815
(318) 281-1434

NATCHITOCHES
P. O. Box 677
Natchitoches, LA 71458-0677
(318) 357-2211

ORLEANS
1300 Perdido St. - #1W23
New Orleans, LA 70112-2127
(504) 658-8300

OUACHITA
122 St John St #114
Monroe, LA 71201-7342
(318) 327-1436

PLAQUEMINES
P. O. Box 989
Port Sulphur, LA 70083-0989
(504) 934-3620

POINTE COUPEE
211 E. Main St.
New Roads, LA 70760-3661
(225) 638-5537

RAPIDES
701 Murray St.
Alexandria, LA 71301-8099
(318) 473-6770

RED RIVER
P. O. Box 432
Coushatta, LA 71019-0432
(318) 932-5027

RICHLAND
P. O. Box 368
Rayville, LA 71269-0368
(318) 728-3582

SABINE
400 Capitol St. - #107
Many, LA 71449-3099
(318) 256-3697

ST. BERNARD
8201 W. Judge Perez - Rm. 104
Chalmette, LA 70043-1696
(504) 278-4231

ST. CHARLES
P. O. Box 315
Hahnville, LA 70057-0315
(985) 783-2731

ST. HELENA
P. O. Box 543
Greensburg, LA 70441-0543
(225) 222-4440

ST. JAMES
P. O. Box 179
Convent, LA 70723-0179
(225) 562-2330

ST. JOHN
1801 W. Airline Hwy
LaPlace, LA 70068-3344
(985) 652-9797

ST. LANDRY
P. O. Box 818
Opelousas, LA 70571-0818
(337) 948-0572

ST. MARTIN
415 Saint Martin St.
St. Martinville, LA 70582-4549
(337) 394-2204

ST. MARY
500 Main St. - #301
Franklin, LA 70538-6144
(337) 828-4100

ST. TAMMANY
701 N. Columbia St.
Covington, LA 70433-2709
(985) 809-5500

TANGIPAHOA
P. O. Box 895
Amite, LA 70422-0895
(985) 748-3215

TENSAS
P. O. Box 183
St. Joseph, LA 71366-0183
(318) 766-3931

TERREBONNE
P. O. Box 9189
Houma, LA 70361-9189
(985) 873-6533

UNION
P. O. Box 235
Farmerville, LA 71241-0235
(318) 368-8660

VERMILION
100 N. State St. - #120
Abbeville, LA 70510
(337) 898-4324

VERNON
P. O. Box 626
Leesville, LA 71496-0626
(337) 239-3690

WASHINGTON
Courthouse Bldg.
900 Washington St.
Franklinton, LA 70438
(985) 839-7850

WEBSTER
P. O. Box 674
Minden, LA 71058-0674
(318) 377-9272

W. BATON ROUGE
P. O. Box 31
Port Allen, LA 70767-0031
(225) 336-2421

W. CARROLL
P. O. Box 71
Oak Grove, LA 71263-0071
(318) 428-2381

W. FELICIANA
P. O. Box 2490
St. Francisville, LA 70775-2490
(225) 635-6161

WINN
119 W. Main St. - Room 105
Winnfield, LA 71483-3238
(318) 628-6133

OFFICIAL USE ONLY

Address Change

_____

_____

_____

_____

_____

Name Change

_____

_____

_____

_____

Party Change

_____

_____

Remarks

_____

Circle One: **PA** **MV** **RG** **SDA** **SS(Disability)**

Received by: _____

PLACE IN AN ENVELOPE AND MAIL TO YOUR

REGISTRAR OF VOTERS